

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032487

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 3 1962

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VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME		11b. MOTHER'S MAIDEN NAME	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		13. SOCIAL SECURITY NO.	
14. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		15. NAME OF HUSBAND OR WIFE	
IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b)		Undet.	
DUE TO (c)		434.4A	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.	
Arrested Pulmonary Tuberculosis, Bronchopneumonia		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		20h. DATE OF DEATH	
21. I attended the deceased from		21b. and last saw him alive on	
Death occurred at		on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE		22b. ADDRESS	
22c. DATE SIGNED		22d. NAME OF CEMETERY OR CREMATORY	
22e. LOCATION (City, town, or county)		(State)	
22f. DATE RECD. BY LOCAL REG.		22g. REGISTRAR'S SIGNATURE	
22h. ADDRESS		22i. DATE OF DEATH	
22j. NAME OF CEMETERY OR CREMATORY		22k. LOCATION (City, town, or county)	
(State)		22l. DATE OF DEATH	
22m. ADDRESS		22n. DATE OF DEATH	
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

William Blackburn

Licensed Embalmer No.

3962

P. O. Address

1221 N. Grand Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.